

**CALIFORNIA DEPARTMENT OF MENTAL HEALTH (DMH)  
FEDERAL MEDICAID MANAGED CARE REGULATIONS**

**IMPACT SUMMARY:**

<b>SUBJECT AREA</b>	<b>DMH AND MENTAL HEALTH PLAN STRATEGIES</b>
Availability and Accessibility of Services	County Mental Health Plans (MHPs) are required to set up new processes for evaluating whether there are enough qualified providers to deliver medically necessary services to the Medi-Cal beneficiaries they serve. MHPs must re-evaluate whenever there's a significant change in the number of providers or the rates they pay their providers and report to DMH on the changes.
External Quality Reviews	DMH contracted with APS Healthcare Midwest to conduct annual external quality reviews (EQRs) of each county mental health plan (MHP). The EQR contractor will evaluate the quality of care, quality outcomes, timeliness of, and access to, the services being provided to beneficiaries in each MHP.
Provider Selection and Certification	MHPs are required to have written policies and procedures on provider selection, provide written notice to practitioners with whom the MHP decides not to contract, and prohibits MHPs from discriminating against particular providers.
Beneficiary Informing Materials	DMH contracted with MAXIMUS, Inc. to develop a booklet for beneficiaries of each MHP that will provide more information about the MHP and about the beneficiaries' rights than has been available in the past. The booklets are expected to be completed in early October 2004.
Providers Not Accepting New Clients	MHPs are required to have a way to ensure that beneficiaries will know if a provider is not accepting new clients. MHPs may do this is, for example, by including the information on the MHP's provider list.
Advance Directives	MHPs are required to inform adult beneficiaries of their rights under state law in the area of advance directives. Basic information will be included in the MHP's informing booklet. DMH Letter No.: 04-08 on the DMH website has more information on advance directives.
Compliance Plans	MHPs are required to develop and follow Compliance Plans to ensure that the MHP and its employees follow all federal and state laws and rules for receiving federal and state funds, correct problems when they're found and identify and report potential fraud and abuse. MHPs have been able to attend trainings and participate in monthly meetings on this topic through the California Institute for Mental Health (CIMH).
Authorization Systems	MHPs now have specific timeframes for making decisions on a provider's request for payment authorization of services the provider plans to deliver to a beneficiary. MHPs must decide on most requests within 14 calendar days; but MHPs must decide on expedited authorization requests in three working days. In some cases extensions of up to 14 calendar days can be made. The MHPs must have written policy and procedures on their authorization processes.
Practice Guidelines	MHPs must adopt two practice guidelines through a formal process that involves providers. Practice guidelines help providers and the MHPs to make decisions about utilization management, beneficiary education, coverage of services, and other areas based on the most current information in the mental health field.
Grievance and Appeal Processes	MHPs are required to separate their former grievance process into an appeal process to respond to problems involving the denial of services and a new grievance process to respond to other problems a beneficiary might have with the MHP. The MHP must decide on an appeal in 45 days. In some cases, if the beneficiary's health is at risk, a expedited appeal decision would

	be made in three calendar days.
Expedited State Fair Hearings	Beneficiaries may request an expedited fair hearing if they believe a delay would put their health at risk. If the State Hearing Office at the State Department of Social Services agrees, the fair hearing decision would be issue in three working days.
Quality Improvement Activities	Two of the quality improvement activities that the MHPs have been required to do each year must now meet the standards that will be used by the EQR contractor to validate the activities, which are called Performance Improvement Projects or PIPs. MHPs may participate in weekly conference calls with CIMH and DMH to discuss progress and ask questions about PIPs.
Emergency Notices between Hospitals and MHPs	Hospitals are required to notify MHPs within 24 hour of a beneficiary's admission for emergency psychiatric inpatient hospital services. Previously, the MHP could deny payment to the hospital if notice was not provided. Now the MHP, in many cases, may only deny payment if the hospital doesn't notify the MHP within 10 days.
Post Stabilization Services	"Post-stabilization care services" means covered services, related to an emergency medical condition, that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or, under the circumstances described in Exhibit A, Attachment 2, Section E, to improve or resolve the beneficiary's condition. Post-stabilization care services include psychiatric consults in an emergency room following the initial evaluation to be post-stabilization services, if the consult does not result in a determination that the beneficiary must be admitted for emergency psychiatric inpatient hospital services. Post-stabilization services also include medically necessary acute psychiatric inpatient hospital services after the emergency psychiatric condition has been resolved.
Interpretation/Translation Services	The federal requirements are consistent with the MHPs' current Cultural Competence Plans.
Notices of Action	When an MHP denies or changes a provider's request for authorization of payment for services, the MHP must send the beneficiary a "Notice of Action" that tells the beneficiary about the MHP's decision, why the decision was made and what the beneficiary can do if the beneficiary doesn't agree. MHPs are now required to send Notices of Action in new situations: when the MHP denies or changes a provider's request for authorization after the beneficiary has already received the services, when the MHP doesn't provide timely services, and when the MHP doesn't complete its grievance or appeal process on time. DMH is working with the Department of Health Services to prepare new Notice of Action forms to assist MHPs to meet these new obligations.

## WAIVERS OF FEDERAL MEDICIAD MANAGED CARE REGULATIONS REQUESTED

WAIVER REQUESTED	OUTCOME
Waiver to use Marriage and Family Therapists (MFTs) to do authorizations, appeals, second opinions	CMS decided that the State could use MFTs in these roles without a waiver, since the federal regulation was not intended to be all inclusive.
Waiver to use Psychiatric Technicians (PTs) in urgent authorizations, appeals	CMS decided that the State could use PTs in these roles without a waiver, since the federal regulation was not intended to be all inclusive.
Waiver to keep the small county risk pool	CMS decided that the small county risk pool could be continued without a waiver, since the regulation that established the requirements for managed care rate setting did not apply to the fee-for-service/cost-based reimbursement arrangement between the State and the MHPs. This decision also means that the State is not required to conduct an actuarial review of the funding arrangements.
Waiver to provide the informing booklet to all Medi-Cal beneficiaries, the informing booklet and a provider list to all beneficiaries who are receiving services from the MHP, and provider lists to any beneficiary on request.	CMS approved this waiver request. The State, through the Governor's Budget, has indicated that it will be asking for additional relief on this issue to allow the State to provide the informing booklet to beneficiaries at the time they first receive services from the MHP and to inform all Medi-Cal beneficiaries that the informing booklet and a provider list is available on request. The State may make this request in the renewal request now being developed.
Waiver to have a single mental health plan per county	CMS decided that the State could continue to have one MHP per county without a waiver based on language in the Preamble to the regulations. CMS is currently reconsidering whether a formal waiver would be preferable, so the State plans to include a waiver request in the renewal request now being developed.
Waiver to continue automatic enrollment/no disenrollment	CMS decided that the State could continue to have automatic enrollment/no disenrollment without a waiver based on language in the Preamble to the regulations. CMS is currently reconsidering whether a formal waiver would be preferable, so the State plans to include a waiver request in the renewal request now being developed.
Waiver to keep current definition of emergency psychiatric condition	CMS decided that the State could continue the existing definitions as long as the State uses the federal prudent layperson standard.
Waiver to allow beneficiaries to take disagreements between beneficiaries and their providers about needed services to appeal and fair hearing without a Notice of Action.	CMS decided that the State could continue to allow beneficiaries to take issues to appeals and fair hearing without a Notice of Action, provided the MHPs did send Notices of Action to beneficiaries when the MHP denied a provider's request for authorization after the provider had delivered the service.
Waiver to provide continuation of services pending resolution of disputes under the standards originally established for the program.	CMS decided that the State could continue the existing standards for continuation of services without a waiver because they provide an additional situation in which beneficiaries may qualify for continuation. Beneficiaries must make timely fair hearing requests to qualify.
Waiver to allow MHPs to deny payment for emergency services to hospitals for failure to inform the MHP of the admission within 24 hours under some conditions.	The State plans to submit this as a new waiver request in the renewal request now being developed. The purpose of the request is to provide a stronger incentive to hospitals to inform MHPs that a beneficiary is in the hospital so that the MHP will be able to provide timely services on discharge.

## CONTENT OF NEW INFORMING MATERIALS

1. Names, locations, telephone numbers of, and non-English languages spoken by current providers in the beneficiary's service area, including identification of providers that are not accepting new patients.
2. Any restrictions on the beneficiary's freedom of choice among network providers.
3. Beneficiary rights and protections. The right to –
  - Receive the beneficiary booklet and other required information.
  - Be treated with respect and with due consideration for his or her dignity and privacy.
  - Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand
  - Participate in decisions regarding his or her health care, including the right to refuse treatment.
  - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
  - Request and receive a copy of his or her medical records and request that they be amended or corrected, unless precluded by federal privacy regulations.
  - Be furnished with timely access to services.
4. Grievance, appeal, and fair hearing procedures and timeframes that must include the following:
  - For State fair hearing—the right to hearing; the method for obtaining a hearing; and the rules that govern representation at the hearing; the fact that, when requested by the beneficiary, services that are already being provide and that the beneficiary's provider has determined to be medically necessary will continue if the beneficiary files a request for state fair hearing within the timeframes specified for filing
  - For grievances and appeals—the right to file grievances and appeals; the requirements and timeframes for filing a grievance or appeal; the availability of assistance in the filing process; the toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone; any appeal rights are available to providers to challenge the failure of the MHP to cover a service.
5. The amount, duration, and scope of benefits available from the MHP in enough detail to ensure that beneficiaries understand the benefits to which they are entitled.
6. Procedures for obtaining benefits, including authorization requirements.
7. The extent to which, and how, beneficiaries may obtain benefits from out-of-network providers.
8. The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes emergency medical condition, emergency services, and post stabilization services.
  - The fact that prior authorization is not required for emergency services.
  - The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.
  - The fact that the beneficiary has a right to use any hospital or other setting for emergency care.
  - The post stabilization care services rules.
9. Cost sharing, if any.
10. How and where to access any benefits that are available through Medi-Cal but are not covered by the MHP, including any cost sharing, and how transportation is provided.
11. Advance directives
12. Additional information that is available upon request, including information on the structure and operation of the MHP.